Australian Secondary Teachers’ Perceptions of Sexuality Education, Abstinence and Safer Sex: Relevance to US Policy


Introduction

This study forms part of an international, comparative study of cultural messages given to young people about adolescent sexual behavior and sexual responsibility. The impetus was the establishment of the United States’ first federal policy on sexuality education in 1996. Through an allocation of $250,000,000 for a five year period that requires an additional 40% state match, the U.S. Congress implemented an abstinence-until-marriage-only (AUMO) sexuality education program for young people (Welfare Reform Act, 1996). Forty-eight states applied for the funds within the first year (Daly & Wong, 1999).

A major goal of the U.S. initiative was to reduce the teen pregnancy rate, which at 83.6 per 1000, is the highest in the industrialized world (Singh & Darroch, 2000). Concerned that the abstinence-only approach would not be effective (available evidence suggests it may not [Office of Technology Assessment, 1992; Wilcox, 1996; Kirby, 1997]), some American advocates for youth began to look at why the teen pregnancy rates in other industrialized countries were lower than those of the United States (Berne & Huberman, 1999). They were particularly interested in policies and programs which aimed to promote the sexual health of young people, especially through sexuality education.

Australia was chosen for the study of sexual health messages for three reasons. First, Americans see themselves as culturally closer to Australians than to Europeans, particularly the Dutch who have the lowest teen pregnancy rates in the western world (Singh & Darroch, 2000). Secondly, teen pregnancy rates in Australia are approximately half as high as those in the United States, and while Australian rates remain higher than those of Western Europe and Scandinavian countries, they continue to decline. Finally, the birth rate for Australian teenage women went from 55 per 1000 in 1971 (Moon, Meyer & Grau, 1999) to 18.5 in 1998 (Australian Bureau of Vital Statistics, 2000). The US birth rate in 1998, by comparison, was 54.4 (Singh & Darroch, 2000).

Declines in the Australian teen birth rate were first attributed to the greater willingness of medical practitioners to provide contraceptives to unmarried women and the liberalization of Australian abortion laws in the 1970s and 1980s (Moon, Meyer & Grau, 1999). The 1983 Medicare revision also made it easier for young people to gain access to free and confidential health services. More recent factors included Australia’s response to the HIV/AIDS pandemic. Young people were identified as a priority, and schools were seen as an important site for prevention activities. Funding was made available for curriculum development and in-service training to build the capacity of teachers to undertake HIV/AIDS and sexuality education (Department of Community Services and Health, 1988). Even in schools of more conservative states like Queensland, Human Relationships Education has become the norm (Logan, 1991).

The Australian government was very specific about the education it required and would fund. Factual information about HIV/AIDS must be provided within the context of sexuality and relationships; the curriculum must build upon and promote student self esteem, communication and decision-making skills; it should encourage students to examine critically and understand their own and others’ values; and students should explore the total range of choices in preventing sexually transmitted diseases, including the right to say no (Department of Community Services and Health, 1989). Evaluation in the 1990s reveals that Australian young people demonstrate a stronger knowledge base about HIV/AIDS and greater condom use than before (Lindsay, Smith & Rosenthal, 1998), supporting the value of HIV/AIDS education.

Schools and teachers played a key role during the nineties in promoting the sexual health of young people in Australia. Classroom discussions, facilitated by a skilled practitioner, provided an environment in which complex issues were explored and debated (Milton, 2000). However, the literature revealed no nationwide qualitative studies of teachers to determine what messages are given to students about sexual behavior and sexual responsibility. This study offers insights into how Australian teachers see their roles in sexuality education, the messages they believe are important to convey to students, and their perceptions of instruction regarding abstinence and safer sex practices on the sexual health of students.

Methods

This study was part of a qualitative research project to determine the sexual health messages given to Australian adolescents by parents, teachers, clergy, support staff and media. The Yearbook of Australia (1996) provided demographic characteristics to guide the sampling process. Because approximately 73% of Australians reside in state or territory capitals, the five major capitals—Adelaide, Brisbane, Melbourne, Perth and Sydney—were selected as the organizing regions for conducting the focus groups.
Sampling

Secondary schools were defined as the primary sampling unit. Four schools were chosen within 250 kilometers of each of the capital cities using specific demographic characteristics. The resulting sample of 19 schools reflected the overall demographic profile of Australia for the following characteristics: population density (such as urban, suburban, town, or rural schools), affiliation (such as state, Catholic, independent schools), gender (such as coed, all-boy or all-girl schools), socioeconomic status of the school community, ethnicity, and school size. Principals selected teachers for the focus groups. Two types were sought: all teachers who have formal responsibility for the sexuality education component of the curriculum and other teachers judged to have "Informal" responsibility; that is, teachers who have strong rapport with students and to whom students turn for advice and support. The focus groups included a total of 134 secondary teachers including over 80% of the teachers with formal responsibility for sexuality education in the selected schools.

Instrumentation

The focus group guide was developed by three American adolescent sexuality specialists and six Australian specialists in education, sexuality, counseling and adolescent medicine. Sections included questions about the curriculum, desirable skills of a sexuality education teacher, important messages that teachers give, messages about abstinence and safer sex, and the materials and resources used (see Figure 1) Each focus group was conducted by a moderator with an assistant who registered participants, collected consent forms, recorded the sessions on audio tape and took field notes during the focus groups. One person with expertise in adolescent sexuality moderated all except one of the groups, where she was the assistant moderator. Protocols were followed as suggested by Krueger (1998) and Debus (1995).

Analysis

Upon completion of 19 focus groups, the audio tapes were transcribed and analyzed for trends and conceptual themes. An index system was constructed for questions using line item text units and index tree nodes that emerged from the data (from Nudist software) . Index tree nodes are coding systems that allow researchers to seek patterns, pursue hunches and themes in the data, express and test hypotheses and develop theories. Text units in this study were analyzed and coded, revealing response patterns. Patterns and themes were summarized in node reports under major headings. The findings were reviewed for feedback by the Australian researchers who served as assistant moderators.

Results

Teachers indicated that Australian sexuality education programs typically begin in primary years, with more formal coverage following in grades 4 and 5 emphasizing puberty, growth and development, menstruation, biological and family aspects. They reported that in many schools, outside service programs called Family Life and Life Education supported the school programs with afternoon and evening sessions for parents and children. Secondary sexual health units were taught in Personal Development, Human Relationships Education, religious education, health education, physical education, science or biology courses. Curricula pertaining to sexual health were usually required through grade 10 after which 10-25% of students took additional elective courses. In one school, teachers reported that its administration had removed its sexual health program citing crowding in the curriculum and parental complaints. However, some teachers suspected the discomfort was at the school administrative level.

Content areas most frequently addressed at the secondary level were: relationships, growth and development, reproduction, contraception, HIV/AIDS, sexual orientation, abortion, pregnancy, birth and parenting, marriage, stereotypes, gender equity, sexual harassment, self esteem, emotional issues and whole person sexuality. Teachers said sexuality issues were covered in multiple grades and in multiple courses, particularly in Catholic schools.

Teachers used the school curriculum as a starting point, but the majority indicated that they followed the students' lead by answering their questions and utilizing teachable moments. This was especially true of teachers identified as having excellent rapport with students. Discussions, videos, questions and answers were identified as the primary methods. Except for Teenagers Guide to the Galaxy, most of the videos mentioned were more clinical--Miracle of Life, Where Did I Come From, The Fight to be Male, Birth of a Baby. Other methods used included kits, models, texts, question boxes, field trips and demonstrations. Teachers indicated significant coverage of condom and contraceptive use, including emergency contraception. Catholic girls school teachers reported significant instruction about protection, particularly in year 10, but Catholic boys teachers did not specifically mention contraception.

Important Messages

A nominal group process was completed with each focus group to determine the primary messages given to students about sexual behavior and responsibility. Table 1 presents a composite of the expressed messages
given by teachers. "Protect yourself and others" was the first and most consistent message from all sites. Four additional prominent messages were: acquire knowledge; explore and develop values; be responsible for your actions and their consequences; and use decision-making skills to inform decisions. The two additional messages reported in Catholic schools were "understand and respect yourself and others" and, "make decisions guided by full knowledge and your values."

The Australian teachers in these focus groups generally presented sexuality in a positive light but warned of negative consequences. Said one teacher: 'Sexuality is normal, so why should it be negative? Our kids need to see that it is a part of everyday living. They have to deal with it and need to be positive about it. If they are not, they've got a lifelong problem.' Teachers expressed the idea that when sexuality is presented from a positive view it empowers young people to be in control, to be 'the practitioners of their own sexuality and expression.'

After discussing important messages, teachers were specifically asked "What do you say to students about when it is okay to have sex, if anything?" In most groups, there was a pause before the responses. The most common response was 'we don't say anything about that.' Other responses included: when they are comfortable; when they decide they are ready; when they are protected; when they are able to take responsibility for their actions; or, when they reach legal age.

These responses were followed with the probe "What do you say about abstinence until marriage, if anything?" Most teachers indicated that they did not bring up the concept of abstinence except in the contexts of a behavioral option or an effective protection against pregnancy and sexually transmitted infections (STI). One teacher indicated that she would teach abstinence until marriage as a moral imperative. Many expressed that it was not important and even hypocritical.

Among the Catholic schools, three positions emerged: teaching the Catholic stance of abstinence except within marriage, supporting sex only in committed and loving relationships, or "passing" on making moral judgments. Catholic teachers had many comments on the issue.

To be honest, there are more important messages to give than abstinence until marriage...that’s down the list.'

I just don’t know if we can have one rule for everyone.’

In the religious education classes, while stating the church’s position that one should abstain from sexual intercourse until marriage, we still teach them about contraception and STDs so that they will know about these things. We accept the fact that many of them are going to be involved (in sex).'

I think we would be hypocritical if we suggested abstinence. Society accepts the fact that relationships occur outside of marriage, so I think for us to say you can’t have sex until you are married is ridiculous and hypocritical.’

When asked what do you say about condoms and contraception, teachers reported giving extensive information including various methods, costs, advantages, disadvantages and how to use them. Videos, contraceptive kits, charts and samples supported their instruction. Condom applications were demonstrated and practiced in most schools, using fingers, rolled paper, cucumbers, bananas, or plastic penis models. A few schools took students on field trips to clinics or hospitals. Some classes included role plays and problem-solving scenarios. Contraceptive education was heavily addressed in years 10-12. Yet some schools introduced the concept in primary level and most schools covered it by year 7 or 8. Teachers in every Catholic school in the study indicated that they taught about condoms, particularly in the context of AIDS prevention, and schools with female students included contraception. The teachers reported that condom instruction significantly increased in the ’90s due to the threat of AIDS.

When asked about unintended pregnancies, the overwhelming majority of non-Catholic school teachers reported that they presented the advantages and disadvantages of all the options. In Catholic schools, the teachers were divided between coverage of all options and not addressing unintended pregnancy at all except to answer student questions when asked. Some schools had creative approaches to these issues such as bringing in a panel of adults who had chosen various options, writing scenarios for decision-making, role playing and bringing in outside experts to do interactive sessions with the students.

‘They do role-playing, word games, interactive things. It’s amazing because you just sit back and watch the kids open up and say so much more...’

‘We stress contraception so they don’t have to fall back on emergency contraception or abortion.’

Toward the conclusion of the focus groups the moderator asked teachers how effective a program would be with teens that focused exclusively on abstaining from sex until marriage. Typical responses included comments like 'it won’t work...not practical...flushing money down the toilet...a waste of money...unrealistic, just
like those sit coms.'

Many teachers suggested alternatives such as funding sports and recreation programs, helping girls develop options, having more open and honest sexuality education, or giving the money to national media campaigns. Some suggested the AUMO approach was 'going to extremes' and that kids would find it hypocritical and rebel. Other teachers were angered by the idea, indicating that young women will particularly suffer from this approach. A few responders thought it might work if other aspects of society would change, particularly the media. One teacher tried to sum up:

'What everyone is saying here suggests that advocates for this approach are prepared to keep kids ignorant, therefore the problems, the pregnancies continue. They are not prepared to change the system, to create the openness... (necessary to solve the problems).'

Discussion

The findings of this study suggest that Australian sexuality education teachers have a strong commitment to an approach that is honest, explicit and comprehensive. Their teaching goes beyond disease prevention to the promotion of sexual health of the whole person within their social context. The messages that the teachers consistently identified as most important for students were: protect yourself and others; gain knowledge about contraceptive choices and how to protect against sexually transmitted infections; learn about and value relationships; and act in accordance with your own values. In addition to the important messages, two macro-level themes emerged from the teachers’ dialogues—autonomy of choice and social justice. Respect for autonomy of choice about one’s sexuality is supported within two historical contexts of Australian culture. First is the acknowledgement that Australia is a "values plural" society (Logan, 1991); therefore, the state is reluctant to subvert values held within students’ families. Alternative values are openly discussed, but values directives are left to the families except in schools selected explicitly for that purpose.

Autonomy of choice also respects each individual’s right to decide if and when to become sexually active. Australian teachers support students’ rights to a full range of knowledge and values and to create an informed framework upon which to make that decision. The majority of teachers reject directive approaches like abstinence-only education as coercion. The teachers’ hesitation when asked "What do you say to students about when it is OK to have sex, if anything?" suggests that they do not believe it is their role to advise students on this matter.

Social justice is also a prevailing theme in Australian education, compelling most teachers we interviewed to take stands against injustices such as gay, gender or ethnic bashing, and to promote "a fair go for all." However, deeper, more complex social justice issues were discovered. For instance, the reluctance of boys schools in general, and Catholic boys schools in particular, to include contraception in sexual health instruction sexifies the responsibility for pregnancy prevention and perpetuates traditional "gatekeeping" roles for females (Lever, 1995).

Yet, the findings of this study and the companion study of parents (Berne, Patton, Milton, et al, 2000) indicate that a majority consensus has been created among parents, teachers, politicians and educational policy leaders with regard to sexuality education in Australian schools. While investigation into any direct relationship between educational efforts and the reduction in teen pregnancies and STIs has not been conducted, the facts remain that both problems have declined over the last decade to rates less than half of those in the US. What implication might these findings have for American policy?

The messages given to young people in Australia differ sharply from those established by policies of the United States government over the last two decades. The American abstinence education legislation supports "educational and motivational programs that have as its exclusive purpose teaching the social, psychological and health gains to be realized by abstaining from sexual activity" (Welfare Reform Act, 1986). Importantly, discussion within these programs of sexual activity, contraception, condoms or sexual orientation other than heterosexuality is strictly forbidden, although alternatively funded parallel programs could do so if such funds were available (Wilson, 2000).

Within the past two years, Congress has created two additional funding streams for AUMO moneys, and President George W. Bush has pledged to "elevate abstinence education from an after-thought to an urgent policy" by increasing the AUMO annual allocation to $135,000,000 (Dailard, 2000). The influx of AUMO funds has affected state and local policies for sexuality education. Districts that switched their policies during the 1990s were twice as likely to move toward abstinence focused policies as to comprehensive approaches (AGI, 2001). In some regions such as the South, 55% of schools now teach AUMO whereas 5% teach comprehensive sexuality education (AGI, 2001).

There is a strong disconnect between American politicians’ drive to promote abstinence-only education (Dailard, 2001) and what teachers, parents and teens think should be taught in schools (Kaiser Family Foundation,
Support for sexuality education including both abstinence and safer sex messages is over 90%, an all time high (Hickman-Brown, 1999).

Furthermore, research on the effectiveness of sexuality education programs show that comprehensive approaches produce more desirable behavior changes among teens (delayed first intercourse, fewer partners, greater use of condoms) while AUMO programs have not demonstrated success thus far (Wilcox, 1996; Kirby, 1997).

More qualitative research among American teachers, parents and youth is needed to bring focus to this dilemma. If there is a majority consensus in America, as surveys suggest, it must be brought front and center with political and religious leaders to modify the national policy.

Conclusions

AUMO policies have important implications for young people. U.S. teenagers are among the youngest in the world to initiate sexual intercourse (Durex, 1998). With inadequate sexuality education and discouragement from seeking reproductive health services, many could face greater risk of sexually transmitted infections, HIV and teen pregnancy as they become sexually active.

As seen in both Australia and the U.S., sexuality education outcomes in schools are directly influenced by national policies. The promotion of adolescent rights for sexual health must therefore be debated at the policy level. We can learn from Australia and other countries about how to develop policies which create programs that work for our young people in a plural-values society. Teachers, parents and young people express support for successful and responsive policies (Howell, 2001). As health professionals, we must find ways to translate their support to political will for the implementation of programs that meet the needs of American young people. As other cultures have adapted, so must we.

References


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